STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255284	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage House Nursing Center	3103 Wisconsin Avenue Vicksburg, MS 39180

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, record review, and facility policy review, the facility failed to ensure Resident #5's right to reasonable accommodation of her physical limitations by not maintaining a call light within reach and not providing a call light she could independently activate to request assistance, for one (1) of nineteen (19) residents sampled. Findings include:A review of the facility's policy, Call Light/Bell revealed, Purpose.provide the resident a means of communication with staff members.Procedure 1. Ensure resident has call light in reach when in resident room.7. Place the call light within the resident's reach before leaving the room.A record review of the Face Sheet revealed the facility admitted Resident #5 on 10/25/24 with diagnoses including Hemiplegia and Hemiparesis following Cerebral Infarction affecting the left non-dominant side.A record review of the Functional Assessment dated 2/18/26 revealed Resident #5 had upper one-sided limitations, was dependent, and required maximal assistance with all activities of daily living (ADLs).A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/18/26 revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of three (3), which indicated the resident's cognition was severely impaired.On 02/23/2026 at 1:45 PM, during an observation, Resident #5 was in bed and stated she wanted water. The call light was positioned between the bed rail and mattress, hanging near the floor and out of reach. A water pitcher was observed on the bedside stand. The resident was unable to access the call light. The Physical Therapist Assistant (PTA) retrieved the call light from between the bed rail and mattress and confirmed it had been out of the resident's reach. The resident had a dome-shaped soft call light and was unable to independently press the button to request assistance.On 02/25/2026 at 12:06 PM, during an observation, Resident #5 was seated upright in a chair with a splint in place on the left arm. The call light was observed on the bed and was again out of the resident's reach.On 02/25/2026 at 9:02 AM, during an interview, the Consultant and Administrator reported that after meeting with therapy staff, the facility decided to order a different type of call light to allow Resident #5 to activate a bump style device and added an intervention to increase rounding to every hour.On 02/25/2026 at 2:56 PM, during an interview, the Director of Nursing (DON) stated Resident #5 had a splint related to a prior stroke and confirmed a tent-style call light had been ordered because the resident was unable to activate the current device independently.On 02/26/2026 at 3:12 PM, during an interview, the Administrator stated staff were expected to follow established guidelines and ensure resident needs were met.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview, record review, and facility policy review, the facility failed to ensure a resident was evaluated for continued need of a PRN (as needed) psychotropic medication after fourteen (14) days for one (1) of five (5) residents reviewed for unnecessary medications, Resident #9. Findings include:A review of the facility's policy, Psychotropic Medications, with a latest review date of 02/25, revealed, . The facility will not use Psychotropic medications unless it is necessary to treat a specific condition as diagnosed and documented in the clinical record. PRN orders for psychotropic medications will be limited to 14 days unless the physician identifies the rationale to extend the medication beyond 14 days. PRN anti-psychotic drugs will be limited to 14 days and will not be renewed unless the physician evaluates the resident for appropriateness of the medication.Resident #9A record review of the Face Sheet revealed the facility admitted Resident #9 on 4/30/21 and she had diagnoses including Alzheimer's Disease.A record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/22/25 revealed Resident #9 required a Staff Assessment for Mental Status and had short- and long-term memory problems and cognitive skills for daily decision making were severely impaired.A record review of the Order Summary Report with active orders as of 02/26/2026 revealed Resident #9 had a Physician's Order, dated 1/30/26, for Lorazepam Concentrate 2 milligrams (mg)/milliliter (ml), Give one (1) ml by mouth every four (4) hours as needed for Anxiety. There was no 14-day stop date indicated on the order.A record review of the facility's GDR (Gradual Dose Reduction) List for January 2026, provided by the Director of Nursing (DON), revealed Resident #9 had lorazepam one (1) mg every four (4) hours PRN, with a notation indicating PRN anxiety medication should be limited to fourteen (14) days then reassessed.A record review of the facility's IDT (Interdisciplinary Team) Psychotropic Dashboard February 2026, provided by the DON, revealed Resident #9 had Ativan one (1) mg every four (4) hours PRN beginning 12/12/25, with comments indicating PRN Lorazepam discontinued then reordered seven (7) days later.A record review of Resident #9's Medication Administration Record (MAR) for 2/1/2026 through 2/28/2026 revealed the PRN Lorazepam order initiated 01/30/2026 continued beyond fourteen (14) days without documented physician evaluation for continued need. As of 02/22/2026, the resident had received seven (7) doses after the fourteen (14) days.On 02/25/2026 at 11:10 AM, during an interview, Registered Nurse (RN) #1 reported Resident #9 had been on hospice services since December. She stated the resident had increased behaviors after Seroquel was discontinued and that Lorazepam dosage had been increased due to agitation.On 02/25/2026 at 2:20 PM, during an interview, RN #2 reported Resident #9 experienced anxiety, behaviors, and pain and had PRN orders for Lorazepam and Morphine. She stated she was unsure how often the PRN medications were administered.On 02/26/2026 at 1:00 PM, during an interview, the DON reported she was aware of the fourteen (14) day limitation for PRN anxiety medications and aware of the pharmacist recommendations. She stated she discussed the recommendation with the Hospice Nurse in January but did not follow through to ensure the medication was reassessed. She confirmed the medication should have been evaluated for continued need after fourteen (14) days.On 02/26/2026 at 3:25 PM, during an interview, the Administrator reported she expected staff to follow regulations and guidelines for psychotropic medications and was not aware the fourteen (14) day reassessment had not occurred.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on observation, interview, record review, and facility policy review, the facility failed to ensure a Minimum Data Set (MDS) assessment was coded accurately to reflect a resident's tobacco use for one (1) of nineteen (19) residents whose MDS assessments were reviewed, Resident #46.Findings include:A review of the facility's policy, Resident Assessment, with a latest revision date of 09/19, revealed, An assessment will be completed on each resident utilizing the MDS (Minimum Data Set) . The Registered Nurse is responsible for verifying the completion of the assessment. The completed assessment guides the staff in identifying key information about the resident and serves as a basis for identifying resident specific issues and objectives in order to develop a care plan. This process assists the resident in reaching the highest practicable physical, mental and psychosocial well-being . Any health professional that completes a portion of the assessment must sign and certify the accuracy of the portion of the assessment that they have completed .A record review of the Face Sheet revealed the facility initially admitted Resident #46 on 6/11/25 with diagnoses including Tobacco Use.A record review of the Smoking Screening dated 10/21/25 revealed Resident #46 smoked or used tobacco products.A record review of the Significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/12/25 revealed Resident #46 had a Brief Interview for Mental Status (BIMS) score of fifteen (15), which indicated he was cognitively intact. A review of Section J1300 indicated no tobacco use.On 02/23/2026 at 1:20 PM, during an observation, Resident #46 was observed being assisted outside for a smoke break with a Certified Nurse Aide (CNA).On 02/24/2026 at 1:50 PM, during an interview, CNA #1 confirmed Resident #46 smoked daily.On 02/26/2026 at 12:05 PM, during an interview, Registered Nurse (RN) #3 confirmed she completed Resident #46's Smoking Screening dated 10/21/2025 and the Significant Change MDS with an ARD of 11/12/2025. She confirmed tobacco use was coded as no on the MDS and stated this was done in error and overlooked. She confirmed she was responsible for the accuracy of the MDS.On 02/26/2026 at 3:00 PM, during an interview, the Administrator stated she expected MDS staff to code assessments accurately to reflect the resident's care and status.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, record review, and facility policy review, the facility failed to implement a comprehensive care plan intervention for one (1) of 19 sampled residents (Resident #5). Findings include:A review of the facility's policy, Care Plan Process (revised 12/2024) revealed, .Regulations require facilities to complete.a comprehensive, standardized assessment of each resident's functional capacity and needs.The results of the assessment.are to be used to develop, review, and revise each resident's comprehensive person-centered plan of care.A record review of the Care Plan Detail for Resident #5 revealed a Focus of The resident is Moderate risk for falls. with an Intervention of Be sure The resident's call light is within reach.On 02/23/2026 at 1:45 PM, during an observation, Resident #5's call light was positioned between the bed rail and mattress, hanging near the floor and out of reach. The resident was unable to access the call light. On 02/25/2026 at 12:06 PM, during an observation, Resident #5's call light was on the bed and was again out of the resident's reach.On 02/25/2026 at 3:09 PM, in an interview with the Director of Nursing (DON), she stated her expectation is that staff take the time to learn each resident, understand their individual needs, and ensure those needs are consistently met.On 02/26/2026 at 3:12 PM, in an interview with the Administrator, she stated her expectation is that staff follow established guidelines, policies, and procedures for all residents to ensure safety and appropriate care.A record review of the Face Sheet revealed the facility admitted Resident #5 on 10/25/24 with diagnoses including Hemiplegia and Hemiparesis following Cerebral Infarction affecting the left non-dominant side.A record review of the Functional Assessment dated 2/18/26 revealed Resident #5 had upper one-sided limitations, was dependent, and required maximal assistance with all activities of daily living (ADLs).A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/18/26 revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of three (3), which indicated the resident's cognition was severely impaired.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation, interview, and facility policy review, the facility failed to ensure staff maintained competency in food safety practices by failing to properly calibrate a food thermometer prior to checking food temperatures for one (1) of three (3) kitchen observations. Findings include:A review of the facility's policy, Calibration of Thermometers, reviewed 05/23, revealed, Procedure: 1. All thermometers are to be calibrated: a. Before each meal.2. Ice Point Method.d. Hold the calibration nut securely with a wrench or other tool and rotate the head of the thermometer until it reads 32 degrees F (Fahrenheit).On 02/24/2026 at 3:37 PM, during an observation and interview with the [NAME] and Dietary Manager (DM), the [NAME] prepared to take temperature readings of food items on the steam table and calibrated the thermometer to 40 degrees Fahrenheit (F). The [NAME] confirmed she believed the thermometer should be calibrated to 40 degrees and stated she had been trained to do so. The Dietary Manager (DM) intervened and pointed to a posted sign instructing staff to calibrate thermometers to 32 degrees Fahrenheit (F). The [NAME] confirmed that an improperly calibrated thermometer could result in inaccurate temperature readings. The DM stated the [NAME] had been trained and in-serviced monthly and that signs were posted in the kitchen as reminders. The DM stated she expected staff to be knowledgeable about their job duties.On 02/25/2026 at 9:46 AM, during an interview, the Administrator stated she had been informed of the improper calibration by the [NAME] in the Dietary Department. The Administrator stated kitchen staff and management were responsible for maintaining competent food safety practices and that she expected staff to follow their training and perform their duties competently.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and staff interview the facility failed to ensure sanitary food handling practices were maintained by failing to sanitize a food thermometer between checking temperatures of multiple food items on the steam table for one (1) of three (3) kitchen observations.Findings include:On 02/24/2026 at 3:37 PM, during an observation and interview, the [NAME] was observed standing at a two-tiered table with individual packs of cleaning wipes on the bottom shelf. The [NAME] retrieved a cleaning wipe and performed an initial cleaning of the thermometer. She then checked the temperature of each food item on the steam table using the same thermometer without sanitizing the thermometer wand between food items. The [NAME] confirmed she checked the temperature of all foods without sanitizing between items and stated it was important to keep the thermometer clean to prevent cross-contamination. During the same interview, the Dietary Manager (DM) confirmed it was the Cook's responsibility to maintain sanitary conditions on the food line. The DM stated staff received monthly in-service training, she expected proper food handling practices, and she would increase monitoring and provide reminders to staff.On 02/25/2026 at 9:46 AM, during an interview, the Administrator stated she had been informed of the kitchen practices. The Administrator stated kitchen staff and management were responsible for maintaining sanitary food handling practices. She stated she would increase monitoring in the kitchen and expected staff to consistently maintain sanitary conditions.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, record review, and facility policy review, the facility failed to implement Enhanced Barrier Precautions (EBP) as required during wound care for one (1) of two (2) wound care observations, Resident #18. Findings include:A review of the facility's policy, Enhanced Barrier Precautions, with the latest review date of 03/24, revealed, Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., . residents with wounds or indwelling medical devices) . Wounds generally include chronic wounds, not shorter-lasting wounds, such as skin breaks or skin tears covered with an adhesive bandage (e.g. Band-Aid) or similar dressing. Examples of chronic wounds include, but are not limited to, pressure ulcers.A record review of the Face Sheet revealed the facility admitted Resident #18 on 12/26/2025 with diagnoses including Hemiplegia and Hemiparesis.A record review of Resident #18's Order Summary Report with active orders as of 02/26/2026 revealed, . Clean Stage 2 pressure ulcer to left hip with normal saline. Apply collagen to wound and cover with dry dressing, daily until healed. One time a day for Stage 2 pressure wound . order date 02/09/2026 . start date 02/10/2026 .A record review of the Part A PPS Discharge Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/08/2026 revealed Section C indicated Resident #18 was rarely/never understood. Section M0210 revealed the resident had one (1) or more unhealed pressure ulcers/injuries.On 02/25/2026 at 9:40 AM, during an observation and interview, wound care was performed by Registered Nurse (RN) #3 and assisted by the Director of Nursing (DON). Enhanced Barrier Precautions signage was observed above the resident's headboard and personal protective equipment (PPE) was hanging on the back of the door. During the wound care, neither RN #3 nor the DON wore a gown while providing and assisting with wound care. During the same interview following the procedure, both staff confirmed they did not wear gowns and stated they forgot to don the required PPE.On 02/25/2026 at 3:00 PM, during an interview, Licensed Practical Nurse (LPN) #1 reported that residents with pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, venous stasis ulcers, or indwelling catheters were placed on Enhanced Barrier Precautions with signage above the headboard and PPE stored in the room. She confirmed Resident #18 had been on Enhanced Barrier Precautions since acquiring the pressure wound and stated staff were educated on EBP and were expected to wear PPE when providing care.On 02/26/2026 at 3:23 PM, during an interview, the Administrator stated she expected all staff to follow Enhanced Barrier Precautions when providing care to residents with wounds or other conditions requiring PPE.